GREATER NEW BEDFORD REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL

1121 ASHLEY BLVD. NEW BEDFORD, MA 02745-2495
NURSE'S OFFICE 508 998-3321 EXT 204/205. FAX 508 998-4647

PARENT/GUARDIAN AUTHORIZATION FOR DISPENSING MEDICATION IN SCHOOL

Name of Student: ______________________________________ DOB: ____________

Address: ____ Grade: __________
(Street) (City/Town)

Name of Parent/Guardian: ____

Telephone Number: Home: ____________ Work: _____________Cell:_____________

Emergency Contact if Parent/Guardian not available:

Name: ________________________________ Relationship: _____________

Telephone Number: Home: ______________ Work: __________ Cell: _____________

Please List Allergies to Foods/Medications: ___________________________________

Please List All Medications Currently Being Used: _____________________________

I GIVE PERMISSION TO THE SCHOOL NURSE TO ADMINISTER THE FOLLOWING MEDICATION(S): ____
(NAME OF MEDICATION)

PRESCRIBED BY: ______________________________**TO:**___________________________
(LICENSED PRESCRIBER) (STUDENT)

I GIVE PERMISSION FOR THE ABOVED NAMED STUDENT TO SELF ADMINISTER MEDICATION IF DEEMED APPROPRIATE BY THE SCHOOL NURSE: YES: ____NO:____

I UNDERSTAND THAT I MAY RETRIEVE THE MEDICATION FROM THE SCHOOL AT ANY TIME AND THAT THE MEDICATION WILL BE DESTROYED IF IT IS NOT PICKED UP WITHIN 5 DAYS FOLLOWING TERMINATION OF THE ORDER OR BY THE LAST DAY OF THE SCHOOL YEAR. I UNDERSTAND THAT THE SCHOOL NURSE MAY SHARE WITH APPROPRIATE SCHOOL PERSONNEL INFORMATION RELATIVE TO THE MEDICATION(S) LISTED.

SIGNATURE OF PARENT/GUARDIAN: ____

DATE: __________________

Rev. 6/17